

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155148</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>09/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>NORTH PARK NURSING CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>650 FAIRWAY DR</b> <b>EVANSVILLE, IN 47710</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00150438 and Complaint IN00151385 completed on July 10, 2014.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00155262 and Complaint IN00155865</p> <p>Complaint IN00150438 - Corrected .</p> <p>Complaint IN00151385 - Corrected.</p> <p>Survey dates: September 8 and 9, 2014</p> <p>Facility number: 000069 Provider number: 155148 AIM number: 100288980</p> <p>Survey team: Anne Marie Crays RN TC</p> <p>Census bed type: SNF: 5 SNF/NF: 83 Total: 88</p> <p>Census payor type: Medicare: 11 Medicaid: 71 Other: 6 Total: 88</p> <p>Sample: 4</p> <p>North Park Nursing Center was found to be in</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155148</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>09/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTH PARK NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>650 FAIRWAY DR</b> <b>EVANSVILLE, IN 47710</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1, in regard to the PSR to the Investigation of Complaint IN00150438 and Complaint IN00151385.  Quality review completed on September 10, 2014 by Jodi Meyer, RN	{F 000}			